HEALTH EXAMINATION GUIDELINES
FOR ENTRY INTO
MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS

1. PLEASE READ THE INSTRUCTIONS CAREFULLY BEFORE FILLING IN THE FORM.
2. PLEASE FILL IN THE FORM IN **ENGLISH** LANGUAGE.
3. PLEASE WRITE IN **CAPITAL LETTERS**.
4. THIS FORM HAS **4 SECTIONS**:
   (a) SECTION 1 (PART A AND B) TO BE FILLED BY THE CANDIDATES; AND
   (b) SECTION 2, 3 AND 4 TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM.
6. THE UNIVERSITY / COLLEGE ONLY ACCEPTS MEDICAL EXAMINATION DONE WITHIN **60 DAYS** BEFORE REGISTRATION OR WITHIN **30 DAYS** AFTER REGISTRATION.
7. PLEASE ATTACH ALL THE **ORIGINAL** LABORATORY RESULTS.
8. PLEASE BRING ALONG **CHEST X-RAY FILM AND REPORT** FOR REGISTRATION.
9. PLEASE ENSURE THE X-RAY FILM IS **LABELLED** WITH YOUR NAME AND DATE TAKEN (IN ENGLISH).
10. CHEST X-RAY DONE WITHIN **6 MONTHS PRIOR** TO REGISTRATION CAN BE ACCEPTED.
11. THE UNIVERSITY/ COLLEGE RESERVES THE RIGHT TO **REPEAT** FULL MEDICAL CHECK-UP OR ANY SPECIFIC LABORATORY TESTS SHOULD THERE BE ANY DOUBT IN THE MEDICAL REPORT SUBMITTED. ALL COSTS INVOLVED SHALL BE BORNE BY THE CANDIDATES.
12. THE UNIVERSITY/ COLLEGE RESERVES THE RIGHT TO **REJECT** ANY APPLICATION:
    (a) BASED ON THE RESULTS OF THE HEALTH EXAMINATION; OR
    (b) SHOULD THERE BE ANY EVIDENCE THAT THE APPLICANT HAS GIVEN FALSE INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.

UNIVERSITI MALAYSIA SARAWAK

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT

Passport size photo

PLEASE USE CAPITAL LETTERS

SECTION 1 (To be completed by candidate)
(PART A)

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NO.

NATIONALITY

CONTACT NUMBER

DATE OF BIRTH
D D M M Y Y

AGE

SEX
MALE
FEMALE

MARITAL STATUS
SINGLE
MARRIED

ACADEMIC YEAR
/

STUDENT ID

PROGRAMME OF STUDY

PROGRAMME CODE

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

SECTION 1

(PART B) – Please tick (√) in the relevant box

Declaration of self and family illness. Explain in full if you or your family has any of the following illnesses.
* Immediate family refers to father, mother, brothers / sisters

MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		If "Yes" please state.
	Yes	No	Yes	No	
1. Congenital or inherited disorder					
2. Allergy					
3. Mental illness					
4. Fits, stroke, other neurological disease					
5. Diabetes Mellitus					
6. Hypertension					
7. Heart or vascular disease					
8. Asthma					
9. Thyroid disease					
10. Kidney disease					
11. Cancer					
12. Tuberculosis					
13. Drug addiction					
14. AIDS, HIV					
15. History of surgery					
16. Other illnesses					

Current medication (Long term)

_____ _____

_____ _____

IMMUNIZATION HISTORY (where applicable)	DATE IMMUNIZED				
1. Yellow Fever					
2. BCG					
3. Meningitis (Quadrivalent)					
4. Hepatitis B					
5. Others:					

I hereby certify that the information given above is true. I understand that my application will be rejected if there is any false information given.

....

Date Signature of candidate

SECTION 2 - PHYSICAL EXAMINATION

To be filled by examining doctor

1. BASIC MEASUREMENT	
HEIGHT : _____ m	BLOOD PRESSURE : _____ mmHg
WEIGHT : _____ kg	PULSE RATE : _____ / min
VISION TEST : Unaided : (R) _____ (L) _____ Aided : (R) _____ (L) _____	COLOUR VISION TEST : NORMAL / ABNORMAL

2. GENERAL EXAMINATION			
ITEM	YES	NO	COMMENT
a. DEFORMITIES			
b. PALLOR			
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
f. SKIN DISEASES			

3. SYSTEMIC EXAMINATION			
ITEM	NORMAL	ABNORMAL	COMMENT
a. EYES (including funduscopy)			
b. EARS			
c. NOSE			
d. ORAL CAVITY / THROAT			
e. NECK			
f. HEART			
g. LUNGS			
h. ABDOMEN / HERNIA ORIFICES			
i. NERVOUS SYSTEM			
j. MENTAL CONDITION			
k. MUSCULOSKELETAL SYSTEM			

SECTION 3 - INVESTIGATIONS

URINE TEST *(Please enclose with test results)		
ITEM	DATE TAKEN	RESULT
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. MORPHINE		
e. CANNABIS		
f. AMPHETAMINES TYPE STIMULANT		

BLOOD TEST *(Please enclose with test results)		
ITEM	DATE TAKEN	RESULT
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS C		
c. HIV		
d. VDRL / TPHA		
e. MALARIAL PARASITE		

CHEST X-RAY INFORMATION *(Please enclose with Radiology Report)	
CHEST X-RAY NO.	
DATE TAKEN	
PLACE TAKEN	
REPORT	

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (√) in the appropriate box :

I certify that I have on this date _____ examined

Mr / Ms _____ Passport No. _____

and found him / her :-

☐ IN GOOD HEALTH

☐ HAVING THE FOLLOWING MEDICAL COMPLICATION(S) (Please State)

_____

_____

_____

☐ UNDERGOING TREATMENT FOR: (Please State)

_____

_____

_____

Date : _____

Signature of Doctor : _____

Name of Doctor : _____

Qualification : _____

Hospital/Clinic Registration Number : _____

Official stamp : _____

Remarks By University Official :